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CHRONICLE OF THE WORLD HEALTH ORGANIZATION

Cholera in Egypt

Quarantine

Unification of Pharmacopœias

Tuberculosis

WORLD HEALTH ORGANIZATION
INTERIM COMMISSION

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GENEVA

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Note by the Editor. — The *WHO Chronicle* is published at the end of each month in English, French and Spanish. Russian and Chinese editions are being prepared at the present time. The *Chronicle* is intended to summarize some of the activities of the Organization, without however claiming to be an authoritative record of the official views of the Interim Commission, which are set out in the *Official Records of the WHO*. All correspondence relating to it should be addressed to the Geneva Office. Those who may wish to reproduce the text of this publication or extracts therefrom, more especially in the medical Press, are entirely at liberty to do so.

CHRONICLE OF THE WORLD HEALTH ORGANIZATION

VOL. I, No. 10 October 1947

CHOLERA IN EGYPT

The present cholera epidemic in Egypt is a test of the efficiency of modern public health organization. There is reason to believe that a century ago a similar epidemic could not have been checked and would have claimed numerous victims in parts of Europe. The history of the five epidemics which during the 19th Century used Egypt as a stepping-stone, fully confirms this supposition.

The cholera epidemic made its first appearance on 22 September 1947, in El Kurein (Elkarin) village, Sharkyia Province. As soon as this news reached the Epidemiological Intelligence Service of WHO, notifications of the outbreak in Egypt were sent to all countries liable to infection from travellers coming from Egypt by air, land or sea. This prompt action enabled the Governments concerned to take protective measures without delay.

All countries adjacent to Egypt and those connected with her by airlines took defensive measures against the importation of the disease: some of those taken were even more drastic than those laid down by the International Sanitary Conventions now in force. One country even went to the length of completely closing its frontiers to persons coming from Egypt. Such a measure, understandable as it is during the early stages of an epidemic outbreak in a neighbouring country, would defeat the very object of the International Sanitary Conventions if permitted to remain in force for any length of time, as it would only provoke clandestine violation of the frontier and the illegal entry of individuals who would thus escape all sanitary control.

Statistical details with a description of the epidemic and the sanitary measures taken by the Egyptian Government are set out in the WHO *Weekly Epidemiological Record* (Nos. 40, 41 and 42) and in a statement by Dr. NAZIF Bey, Under-Secretary of State for Quarantine, Egypt (doc. WHO.IC/Q/12).

The sanitary measures taken to localize the outbreak are summarized as follows :

1. Isolation of patients in fever hospitals and isolation camps.
2. Immediate disposal of rubbish or other fly-breeding sources by burning, and then spraying the inside and outside of dwellings with D.D.T. solution.
3. Disinfection of houses of sick and suspected cases.
4. Isolation of contacts of patients and observation of the inhabitants of infected villages.
5. Immediate inoculation of contacts, followed by mass inoculation of the entire population of infected or threatened villages.
6. Control of the purity of the water supplies and the protection thereof.
7. Prohibition of the sale of refreshment, cold drinks and any food or fruit suspected of contamination.
8. Closure of public fountains destined for public use as well as wells and tanks exposed to the risk of contamination, even if they belong to individuals.
9. Closure of public swimming-pools.
10. Prohibition of the mooring of boats in an area within 500 metres from the boundaries of any town situated on the banks of the Nile or a canal. Such boats will not be allowed to approach the shore in such areas.
11. Closure of any public kitchen or any kitchen belonging to restaurants or cafés, if after a 24-hour warning issued by the Medical Authorities to its owner or manager the establishment was still found in a state liable to facilitate the contamination of the food or drinks prepared or served in that establishment.
12. Closures of latrines and cesspits which would be found in the following conditions :
    (a) in the neighbourhood or inside public kitchens or cafés or restaurants, and, as a general rule, in any place where food or drinks are prepared for the use of the public, if such W.C., tanks or latrines in view of their state may facilitate the contamination of food or drinks prepared or served ;
    (b) in workshops or factories, if such W.C., latrines or cesspits are not in a satisfactory state of cleanness.

13. Closure of any drain or W.C. connected with the Nile or with any canal or pond.
14. Closure of any aerated water or ice-factory or any dairy liable to be dangerous to public health.
15. Prohibition of open praying-places situated on the banks of the Nile or any canal, or in the neighbourhood of any well.
16. Prohibition of washing clothes or bathing in the Nile or in any canal.
17. Prohibition of drawing water from any sources other than those approved by the sanitary authorities.
18. Prohibition of fairs or public markets.
19. Prohibition of washing vegetables destined for sale in any places other than those appointed by the sanitary authorities.
20. Chlorination of water taken from rivers and canals in the infected areas.
21. Prohibition of navigation in Ismailia Canal.
22. Prohibition of bus traffic between Cairo suburbs and the infected villages.
23. Abolition of stopping of trains at stations between Ismailia and Cairo, Zagazig excepted.
24. Suppression of outgoing movement of pilgrims from Egypt.
25. Closure of out-patient departments in all Ministry units in the infected provinces.
26. Installation of sanitary water pumps for water supply in the infected districts.
27. Control of traffic between infected and non-infected areas by all routes.
28. Increase of the amount of chlorine, 1 part per million, in the waterworks of all towns and cities.

To enable the health authorities of Egypt to carry out a vaccination campaign—an essential measure in the fight against the epidemic—the WHO Secretariat was authorized to spend a considerable sum of money in the purchase of vaccine, offered to the Egyptian Government immediately news of the epidemic outbreak reached Europe. During the days that followed, Egypt received considerable quantities of vaccine from the U.S.S.R., the United States, the United Kingdom, Iraq, France, Switzerland, Tunisia, Brazil, Iran and Italy.

Contacts and suspected cases were vaccinated first, and the practice was later extended to the whole population of the infected and threatened areas.

The energetic measures taken by the Egyptian Government as well as the steps taken by other Governments to secure international protection, confined the epidemic during its first weeks to a relatively small area covering the provinces in the Nile Delta, more particularly Dakahlyia, Sharkyia and Kaliubyia. [1] [2] Fear of cholera has given rise to rumours of cases in a number of countries closely or remotely connected with Egypt — rumours reported in several cases by the Press. The competent health authorities of Saudi Arabia, Palestine and Italy have emphatically denied the presence of cholera in any part of their territory. Egypt is therefore the only country west of India where cholera is now present.

A meeting of the Expert Committee on Quarantine, announced for 24 November, was summoned earlier so that the cholera epidemic, the measures taken and some technical problems involved might be studied immediately.

The experts met on 13 October and heard a comprehensive statement by Dr. NASIF Bey on the development of the Egyptian cholera epidemic. The origin of the epidemic was discussed at length.

It was impossible to determine with certainty how the cholera vibrio had found its way into the country which had been free from cholera since 1903. The disease could not have been imported by pilgrims returning from Mecca, which in the past was the traditional way by which cholera entered the country, as the Pilgrimage does not take place until later in the year. To prevent the disease from spreading to other parts of the world, 15,000 Egyptian pilgrims who were preparing to leave for Mecca were prevented from sailing. Foreign pilgrims were allowed to proceed by ship through the Canal in quarantine, medical inspections being carried out at Port Said and Suez. Foreign pilgrims in transit who reached Egypt by air were allowed to proceed on the seventh day following cholera vaccination.

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[1] On 16 and 17 October, respectively, cases of cholera were reported from the provinces of Kena and Beni Suef (Upper Egypt).

[2] The total number of cases for the four weeks from 23 September to 20 October (provisional figures) works out as follows :

23-29.IX :	523	cases	and	156	deaths
29.IX.-6.X :	889	»	»	378	»
7-13.X :	1,303	»	»	551	»
14-20.X :	4,566	»	»	2,075	»
Total :	7,281	»	»	3,160	»

Another problem discussed by the experts was the use of vaccine. The vaccines received by Egypt from the various countries appeared to differ appreciably in concentration. It is common practice to inject 12 billion [1] germs in two doses, the first of 4-5 billions and the second of 7-8 billions. As the strain of cholera vibrio used for the various preparations of vaccines is not identical, some vibrios being three times larger than others, it follows that the various types of vaccines do not contain the same number of germs per c.c., for if they did they would vary considerably in concentration, some being fluid and others thick. Moreover, mice will withstand the injection of 4 billion vibrios of some strains, but will die if injected with only 2 billions of another. The Egyptian health authorities were confronted with a difficult problem, and being in need of large quantities of vaccine, they had to use preparations coming from various countries and requiring different methods of application. This served to emphasize the urgent need to standardize the vaccines, and the question was therefore referred to the WHO Expert Committee on Biological Standardization.

The quarantine measures to be adopted by threatened countries were also discussed. The experts unanimously agreed that the provisions of the International Sanitary Conventions were in every way adequate, [2] and emphasized the fact that Article 15 of the 1926 and 1944 Maritime Convention could not be construed as empowering countries to enforce quarantine measures more rigorous than those laid down by the Conventions which call for :

(a) surveillance for travellers adequately protected by vaccination ;

(b) surveillance and *medical examination* for those who have not been vaccinated.

Medical examination for suspected cases enables health authorities to subject such cases to any supplementary investigation that may be required, including bacteriological examination of stools, and *observation.*

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[1] Billion is here used in the French and American sense of one thousand millions.

[2] See Articles 29 to 34 of the International Sanitary Convention, 1926, as amended by the International Sanitary Convention, 1944, and Articles 30 to 33 of the International Sanitary Convention for Aerial Navigation, 1933, as amended by the International Sanitary Convention for Aerial Navigation, 1944.

QUARANTINE

First Meeting of the Expert Committee, held at Geneva in October 1947.

As has already been stated, a meeting of the Expert Committee on Quarantine, originally planned for 24 November, was held from 13 to 16 October [1] so that the cholera epidemic, the measures taken to combat it and some of the problems involved might be discussed by the Experts.

The question of international vaccination certificates was discussed following a protest by the Government of India, concerning a request made by the Hong Kong, Singapore and Malayan Union authorities, that all smallpox vaccination certificates should be countersigned by a medical officer attached to a government or municipal service. The Committee noted that Article 42 of the Maritime Conventions of 1926 and 1944 left it to the authorities of the country of arrival to decide whether or not the traveller had been adequately vaccinated. It was therefore in the interests of the traveller to present a trustworthy certificate. The Experts recommended that health authorities should accept as valid, and consequently as exempting the bearer from further revaccination and quarantine restrictions, the form of " International Certificate ", when completed or authenticated by a medical officer in government or municipal service, or in government-approved institutions. This recommendation, if accepted by Governments, would be of great value to the traveller, for, once in possession of a duly authenticated International Certificate testifying that his vaccination has

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[1] The following attended this meeting:

Dr. DUJARRIC DE LA RIVIÈRE, Assistant Director of the Pasteur Institute, Paris;

Dr. G. L. DUNNAHOO, Chief of the Foreign Quarantine Division of the United States Public Health Service, Washington;

Dr. G. D. HEMMES, Inspector of Public Health, Utrecht;

Dr. H. E. Mohammed NAZIF Bey, Under-Secretary of State for Quarantine, Ministry of Public Health, Egypt;

Dr. P. G. STOCK, Medical Adviser, Ministry of Health, London (elected Chairman);

Dr. W. W. YUNG, Director, Department of Epidemic Prevention, National Health Administration, Nanking.

Secretariat: Dr. Y. BIRAUD, Director, Division of Epidemiology and Public Health Statistics;

Dr. G. STUART, Chief of the Sanitary Conventions and Quarantine Service, Secretary of the Committee.

been successful, he could feel sure that he would not be subjected to revaccination or quarantine restrictions by the health authorities of the port of arrival. The Experts also recommended that even certificates not so authenticated should be accepted, under the terms of Article 42 of the 1926 and 1944 International Sanitary Conventions, although it is recognized that the health authorities of the port of arrival have, in this case, the right to refuse them if they so desire. It was decided that the forms of International Certificates and the question of their endorsement should be referred to the Expert Committee on International Epidemic Control and that the question of their simplification should be considered during the revision of the Sanitary Conventions. The Experts considered that no photograph or fingerprint should be required on certificates when the holder was in possession of a passport or identity card. The certificates might be drawn up both in the language of the issuing country and in one of the official languages of the 1944 Conventions (English or French). The Committee further discussed the possibility of revising the International Certificate of Vaccination against smallpox, particularly with a view to avoiding the terms " reaction of immunity " and " no reaction " which in the past have led to confusion. Dr. STOCK proposed that the certificate should consist of three parts, covering respectively :

I. Vaccination ;

II. Inspection of the results ;

III. Revaccination and inspection of the results in the event of the first vaccination proving unsuccessful.

(In the event of a second unsuccessful vaccination the interpretation of that finding is left to the discretion of the port health authority of the country of arrival.)

The proposed certificate will be submitted to the Interim Commission as amended. If it is approved, the Interim Commission will recommend that Governments recognize and adopt it pending the revision of the International Sanitary Conventions now in force. The Committee was opposed to the issue to persons travelling on urgent business of " Provisional International Certificates " of vaccination and inoculation against pestilential diseases such as was envisaged during the war, as this might entail a complete breakdown of the international system of quarantine protection.

Another question examined was that of inoculation against plague and typhus. The Experts stressed the fact that, under the existing conventions, inoculation against these two diseases could not be required of incoming travellers, and observed that such measures were of little value in the protection of countries receiving travellers from infected areas. In their opinion, disinsectization of the travellers and their belongings by means of D.D.T. or other insecticide was far more efficacious in preventing the importation of these diseases.

The disinfection of aircraft in the event of a true or suspected case of cholera on board was also discussed. This appeared to be a complicated problem if the aircraft is not to be detained at the airports too long, or its fittings damaged. The Secretariat was requested to obtain technical information on the subject. Pending an international agreement on standard methods of disinfecting aircraft, a number of simple routine measures to be taken in case of emergency were recommended.

Inoculation against yellow fever was another problem under consideration. On evidence furnished by the experts of the WHO Yellow Fever Panel, the Committee agreed that infants and young children could be safely inoculated against yellow fever provided that 17-D vaccine was used.

The Committee reviewed the terms of Article 49 of the 1926 and 1944 Conventions and unanimously agreed that, as an effective epidemiological service had now been established by the WHO, bills of health and consular visas should be abolished. The Secretariat was requested to bring this decision to the notice of Governments and to do everything in its power to accelerate the abolition of these obsolete documents.

Finally, the Experts considered the problem of the international testing of yellow-fever vaccine. The Committee approved the recognition by the Interim Commission of a number of laboratories already approved by UNRRA for testing the activity[1] of the yellow-fever vaccine and for its preparation. [2]

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[1] Bogota (Colombia), Yellow Fever Laboratories, National Yellow Fever Service ;

Dakar (Senegal), Pasteur Institute ;

Entebbe (Uganda), Yellow Fever Institute ;

Hamilton (Montana, U.S.A.), Rocky Mountain Laboratory (U.S. Public Health Service) ;

[*Continued on opposite page.*

It was agreed that the measures already undertaken by the Interim Commission for the systematic international testing of yellow-fever vaccine should be put into force as soon as possible in order to ensure the maintenance of the activity of all vaccines in international use, to permit the granting of full approval to institutes at present enjoying only temporary approval, and to provide for the addition of other institutes to the list of approved vaccine producing laboratories.

UNIFICATION OF PHARMACOPŒIAS

First Meeting of the Expert Committee held at Geneva in October 1947.

At its third session, the Interim Commission decided to establish an Expert Committee for the Unification of Pharmacopœias. The background to the work of this Committee, which is a continuation of the Technical Commission of Pharmacopœial Experts of the League of Nations, has been described in a previous number.[1]

Johannesburg (Union of South Africa), South African Institute for Medical Research ;

Lagos (Nigeria), Yellow Fever Research Institute ;

London (England), Wellcome Research Institute ;

New York (U.S.A.), Laboratories of the International Health Division, Rockefeller Foundation ;

Paris (France), Pasteur Institute ;

Rio de Janeiro (Brazil), Yellow Fever Research Institute.

[2] International Health Division of the Rockefeller Foundation * ;

National Institute of Health of the U.S. Public Health Service * ;

South African Institute for Medical Research, Johannesburg * ;

Wellcome Research Institute, London † ;

Yellow Fever Laboratory, Brazilian National Yellow Fever Service, Rio de Janeiro † ;

Yellow Fever Laboratory, Colombian National Yellow Fever Service, Bogota † ;

Pasteur Institute, Dakar §.

* Fully approved.

† Approved, for the time being, for quarantine purposes.

§ Approved, provided vaccine inoculated by the scarification method of the Dakar Pasteur Institute.

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[1] See *WHO Chronicle*, 1947, 1, 77.

The Expert Committee held its first session in Geneva from 13-17 October 1947.[1]

The Technical Commission of the League of Nations had held its last meeting in May 1939, and the first task of the Expert Committee was to consider the Interim Report of that Commission and, in the light of modern developments in pharmaceutical knowledge and science, to draw up a definitive list of drugs to be included in an International Pharmacopœia, the drafting of the requisite monographs being divided amongst its members. This list was divided into three sections : Section A, the primary list for immediate action comprising those drugs extensively used in modern therapeutics and of essential value to the medical profession ; Section B, those drugs not considered as important, for inclusion in a secondary list; while those in Section C were not considered worthy of inclusion. Approximately 250 drugs were listed in Section A, 80 in B and 200 in C.

The main task of the Committee consisted of the careful examination of draft monographs submitted by members which were adopted with minor alterations.

Other matters discussed by the Committee included the possibility of establishing an international nomenclature for new drugs; and the standardization of surgical sutures, dressings, etc.

Amongst its recommendations to the Interim Commission were that, to give a broader international representative opinion, the Committee should be increased by at least three members, and that negotiations should be undertaken to establish a single International Secretariat for Pharmacopœias under the ægis of the WHO or of its Interim Commission.

It is the hope of the Expert Committee that the first draft of the International Pharmacopœia may be published in the course of 1948.

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[1] The following members attended :

Professor H. BAGGESGAARD-RASMUSSEN, Chairman of the Chemical Division of the Danish Pharmacopœia Commission ;

Professor I. R. FAHMY, Professor of Pharmacology, Faculty of Medicine, Cairo;

Professor E. FULLERTON COOK, Chairman of the Committee of Revision of the United States Pharmacopœia ;

Dr. C. H. HAMPSHIRE, Secretary of the British Pharmacognosy Commission (elected Chairman) ;

Professor R. HAZARD, Professor of Pharmacology and Materia Medica at the School of Medicine, Paris, was unable to attend owing to illness.

Secretariat : Dr. W. BONNE, member of the Secretariat of the Interim Commission.

TUBERCULOSIS

First Meeting of the Expert Committee held in Paris in July-August 1947.

The Expert Committee [1] on Tuberculosis met in Paris from 30 July to 2 August 1947 and discussed the practical means of attacking the disease on an international level. The experts presented their conclusions in a report [2] to the Interim Commission at its fourth session held at Geneva in September; but it was decided that the recommendations contained in the report should be further considered by the Members of the Commission prior to the next session.

It was nevertheless agreed that the Executive Secretary be authorized to establish, as an emergency measure, two or three small demonstration teams, to be sent at the request of countries in which tuberculosis had assumed epidemic proportions, to carry out B.C.G. vaccinations. A demonstration team will normally consist of a doctor, a laboratory assistant and a nurse.

It was further agreed that the contradictory reports received from clinical workers with regard to the therapeutic value of streptomycin in tuberculosis justified the convening of a conference of experts in the near future. A number of workers with wide personal experience in the clinical use of the drug or its production will be invited to discuss the hopes and fears which arise from the use of streptomycin in the various forms of tuberculous infection. The next meeting of the Expert Committee on Tuberculosis will be held in February at Geneva.

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[1] The Expert Committee comprised:
Dr. P. D'Arcy Hart, Medical Research Council, London;
Dr. Herman Hilleboe, United States Public Health Service;
Dr. Johannes Holm, State Serum Institute, Copenhagen (elected Chairman);
Secretary: Dr. J. B. McDougall, member of the Secretariat of the Interim Commission.

[2] Doc. WHO.IC/95, 8 August 1947.

THE HOUSING PROBLEM

One of the most difficult problems of the post-war world is that of housing. Not only have numerous dwellings been destroyed during hostilities, but the great economic depression of 1929 caused a slowing-up or indeed complete stagnation in the building programmes of certain countries.

The present overcrowding of dwellings has gravely affected the morale and also the state of health of a large proportion of the urban population. Indeed, it is impossible to combat with any measure of success tuberculosis and other infectious diseases while living conditions fall so far short of the requirements of hygiene. The housing problem concerns not only the architect, the engineer and the economist, but also the public health specialist. It is not sufficient to find the material and labour wherewith to build dwellings on a large scale ; a knowledge of the physiological conditions essential to a healthy life is also required.

It is in this latter field that the Health Section of the League of Nations broke new ground. It collected valuable documentary evidence [1] on the living conditions of rural and urban populations in certain areas of Europe and of other continents, and in 1935, set up a Housing Commission. This body met several times and endeavoured to define sanitary standards indispensable for adequate housing in various regions, taking into account the variations in customs and climate.

An entire range of standards and principles were laid down,[2] especially dealing with hygiene of the environmental conditions in dwellings (temperature, humidity, movement of the air, etc.), space, noise, natural and artificial lighting, sunshine, water supplies, sewage and methods of disposing of household refuse, etc.

The war interrupted the work of the Housing Commission, but the need of a scientific and economic solution of the housing problem is now more urgent than ever. Several United Nations bodies, as well as several specialized agencies, have endeavoured since the end of hostilities to assist in the solution of the problem. The Emergency Economic Committee for Europe (EECE), in August 1946,

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[1] See complete bibliography of the works published by the Health Section on the housing question in the *Bulletin of the Health Organization*, 11, 1945.

[2] See Reports of the Housing Commission in the *Bulletin of the Health Organization*, 4, 4, August 1937, and 8, 4-5, 1939.

set up a Sub-Committee to study urgent housing problems. The Economic Commission for Europe (ECE), which is a branch of the Economic and Social Council of the United Nations, later carried on EECE's task. Under its ægis a new " Housing Group " was formed, with instructions to make recommendations to the ECE. This group, which consists of representatives of 28 States, met at Geneva on 1-3 October 1947. During this session, a permanent body was formed whose task it will be to direct the ECE's attention to the technical and economic means required to supply effective aid to member States.

The discussions showed a definite desire for effective action, chiefly economic, to further the rapid building of dwellings in Europe. A special session was devoted to a debate on co-operation with other institutions. Dr. Yves BIRAUD, who represented the Interim Commission of the WHO as an observer, formally offered the closest co-operation. He pointed out that contact at an early stage in the work between physiologist and sanitary engineer on the one hand and building technicians on the other, would make it possible not only to safeguard the sanitary standards essential to public health, but might also result in a simplification of the building regulations in force with a consequent speed-up of building. Dr. Biraud recalled that the WHO must, under the terms of its Constitution, " promote, in co-operation with other specialized agencies where necessary, the improvement of ... housing ". He further observed that the Interim Commission had officially expressed its desire that the WHO should be adequately represented in all international work on housing and town-planning. It was also hoped that a group of experts might be formed within the WHO to carry on the task of the Housing Commission of the League of Nations Health Section and to supply the " Housing Group " with all the necessary technical information in the field of hygiene and sanitation.

WHO PUBLICATIONS

Epidemiological and Vital Statistics Report.

Knud STOWMAN, WHO epidemiological consultant, gives in Vol. 1, No. 4, of the *E.V.S.R.*, a picture of the incidence of diphtheria throughout the world since the beginning of the war.

A diphtheria pandemic spread over Europe during the last ten years, possibly because artificial immunization was not employed on an adequate scale. This was mainly due to a false sense of security which developed after the rapid decline of the diphtheria prevalence in the 1930's. Over 150,000 people whose lives might have been saved were killed by the disease.

The main focus of the last diphtheria epidemics was in Northern Germany. When the war broke out, the diphtheria incidence in that country, in which vaccination for children was not compulsory, had been increasing for nearly fifteen years. In 1939, the number of diphtheria cases in the " Altreich " amounted to 150,000, and the mortality rate to 5 per cent. In 1942, there were 237,000 cases. Four years later 153,000 diphtheria cases were reported in the American, British and French zones. It is estimated that in the entire German territory for the year 1946 there were possibly 230,000 cases or about the same number as in 1942-1944.

Bohemia-Moravia and Austria formed part of the Central-European areas of high diphtheria incidence during the pre-war years. At the present time the diphtheria incidence in these regions is at the same level. Hungary instituted a regular vaccination campaign, and was therefore not affected by the Central-European epidemic during the war. There were 4,927 cases in 1940, 5,947 during the second half of 1945 and 9,576 cases in 1946 as against 14,500 in 1934. In Northern Europe, Sweden and Denmark—countries in which children were vaccinated on a large scale—resisted the diphtheria wave to a certain degree, while Norway and Finland had severe epidemics. From 1941 to 1946, there were 59,566 cases in Norway, compared with 1,813 during the previous six years. The peak came in 1943 with 22,787 cases. An inoculation campaign was then begun and the next year the number of cases fell to 13,547. Finland was not touched by the epidemic until 1943, but 54,297 cases were reported from July of that year to February 1947.

It was in the Netherlands, being nearest to the focus of infection, that diphtheria did the most damage. The epidemic appeared, as in Norway, on the heels of the invaders. During the years 1941-1946 there were 219,772 cases, as against 8,649 during the previous six-year period. Belgium and France, too, had epidemics culminating in 1943, but the incidence was considerably lower than in the Netherlands. In Switzerland there were 5,302 cases in 1946, a slightly higher figure than during the preceding years. Mediterranean

Europe was hardly affected by the pandemic. Italy reported from 20,000 to 30,000 cases a year, but practically all were from the northern and central parts of the country. There was, however, a considerable increase in the incidence of diphtheria in the Iberian Peninsula, where 27,474 cases were reported in 1940 as against an average of 1,119 in 1931-1936.

The United Kingdom is in a category by itself. With a 1928-1936 median of about 75,000 cases a year, it could not be considered as a low-incidence area, despite the fact that in 1941 there were fewer than 16,000 confirmed cases and that the incidence is still decreasing.

This decrease may be due to the mass vaccination campaign, to a well-organized health service and an almost complete interruption of communications with the European epidemic areas.

The Pacific area also had its difficulties. In Japan, 77,256 cases were reported in 1945 as against an average of 28,677 a year in 1934-1938 and an increase in incidence of diphtheria was also reported from New Zealand and Manila.

The Americas were not affected by the diphtheria pandemic to any great extent.

Diphtheria, during the second world war, became the most important epidemic disease in all that part of Continental Europe where the spread of the disease was not prevented by climatic (or unknown) causes which past experience has shown to be permanent. Apart from the Soviet Union, Poland and the Balkans, for which numerical indications are absent or inadequate, there were some 600,000 reported diphtheria cases a year in Europe. The aggregate toll of deaths from this cause during the war and immediate post-war years is probably not under 150,000.

It is clear from the summary presented by Mr. K. STOWMAN that the diphtheria wave is now receding but only slowly. In the above-mentioned area, 336,000 cases were reported in 1946. This is a first indication of a decline in the number of cases after five years.

It is apparent from these data that the epidemic wrought havoc among populations which were not vaccinated and that tens of thousands of lives might have been saved.

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Vol. I, No. 4, of the *E.V.S.R.* also contains statistical tables on diphtheria, scarlet fever, measles and whooping-cough.

WHO REPRESENTATION

During the period between 20 September and 20 October the Interim Commission was represented by observers who attended or took part in the meetings of the following organizations :

General Assembly of the United Nations, Second Session, Lake Success and Flushing Meadows, U.S.A., September.

Sub-Commission on Statistical Sampling, Lake Success, U.S.A., September.

First Annual Meeting of the World Medical Association, Paris, September.

International Children's Emergency Fund, Executive Board, Lake Success, U.S.A., October.

Panel on Housing Problems (ECE), Geneva, October.

Meeting for the Co-ordination of the Medical and Biological Abstracting Service (UNESCO), Paris, October.

International Social Insurance Conference, VIIIth Meeting, Geneva, October.

Co-ordination Committee of the Economic and Social Council, Lake Success, U.S.A., October.

FORTHCOMING MEETINGS

The Interim Commission will hold its fifth session at the Palais des Nations, Geneva, from 22 January to 7 February 1948.

The Sub-Committee on the Field Services Budget will meet in Geneva on 16 January 1948.

The Committee on Administration and Finance will meet in Geneva on 19 January 1948.

Technical Meetings.

The Expert Committee on Tuberculosis will meet at Geneva, Palais des Nations, some time in February 1948. The precise date will be announced later.

The Expert Committee on Malaria will meet at Washington, D.C., some time in May 1948. The precise place and date of the meeting will be announced later.

2040 A., 2000 F., 1030 Esp., 11/47. Imprimerie de « La Tribune de Genève ».